South Shore
Regional Centre for Education

INTERAGENCY CONSENT FORM TO OBTAIN AND RELEASE CONFIDENTIAL INFORMATION

I, _____ , of _____
Full Name of Guardian *Address*

authorize the sharing of information for the purpose of assessment/treatment among

South Shore Regional Centre for Education (69 Wentzell Dr., Bridgewater, NS, B4V 0A2

And: (please check in appropriate boxes)

- ☐ Nova Scotia Department of Justice
- ☐ Nova Scotia Department of Community Services
- ☐ Nova Scotia Health Authority – Mental Health Services
- ☐ Nova Scotia Health Authority – Specify Provider: _____
- ☐ IWK Health

- ☐ Other: _____
- ☐ Exceptions: _____

Student's Name:_____ Date of Birth (m/d/y): _____

Parent/Guardian(s): _____

Witness: _____

Location: _____ Date: _____

All of the above agencies are bound by strict policies of confidentiality and cannot release or receive your personal information without your authorized consent.